Weill Cornell Medicine

Authorization To Use or Disclose Protected Health Information (PHI)

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ Phone: _____

ST: _____ Zip: _____ NYP#: _____
(if available)

I authorize the release of the following health information:

- ☐ Entire medical record
- ☐ Diagnostic Tests — Date(s): _____
- ☐ Doctor's Notes (from Dr. _____) — Date(s): _____
- ☐ Lab Results — Date(s): _____
- ☐ Pathology Reports ☐ Specimens ☐ — Date(s): _____
- ☐ Radiology Reports ☐ Images ☐ — Date(s): _____
- ☐ Include Alcohol/Drug Treatment information (initial here) _____
- ☐ Include Mental Health information (initial here) _____
- ☐ Include HIV-Related information (initial here) _____
- ☐ Medical Record/Information from outside the institution brought to the practice by me (explain):
  _____
- ☐ All of the above with the exception of: _____
- ☐ Other: _____

Who will <u>release/disclose</u> information:
Name: _____
Address: _____
City, State, Zip: _____

Who will <u>receive</u> information:
Name: _____
Address: _____
City, State, Zip: _____

Reason for Disclosure: _____

This authorization expires: ◯ specific time frame _____, ◯ when record is received, ◯ other (explain)
_____

I understand that:

- By signing this form, I am authorizing the use/disclosure of protected health information as indicated above.
- I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I may revoke this authorization at any time by completing a "Request to Revoke an Authorization" form, which is available at Weill Cornell Medicine's Privacy Office. I understand that I may revoke this authorization except to the extent that action has been taken based on this authorization.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal/state law. Weill Cornell Medicine shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements.
- I may request a copy of this signed form.
- Weill Cornell Medical College may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment.

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient